MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 10305

131

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 23 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1304 W. Lafayette Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: N

3. (a) FULL NAME: EULA ADDIE BALTIMORE

3. (b) Social Security Number: 217-20-0155

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (Sep.)

6.(b) Name of husband or wife: Prince Baltimore

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): August 20, 1921

8. AGE:

Years	Months	Days	If less than one day
27	2	4	...hrs. ...min.

9. Birthplace: Church View, Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER — 12. Name: Robert Wyatt

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Addie Richardson

15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 48 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cem.

Location: Baltimore Md

16. Funeral director: Mrs Katie C. Williams

Address: 322 N. Schroeder St

19. October 24, 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 19 48 at 12:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 19 48 to Oct. 24, 19 48 and that I last saw her alive on October 24, 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	February 1948
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 10-24-48

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10306

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Henry Charles Baumgardner

3. (b) Social Security Number 705-10-7082

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Fannie Herring Baumgardner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1880

8. AGE:

Years	Months	Days	If less than one day
68	1	0	..... hrs. ..... min.

9. Birthplace Adams County, Maryland (Town, county, and state)

10. Usual occupation Engineer for Railway Co.

11. Industry or business

FATHER 12. Name Samuel Baumgardner

13. Birthplace Penna

MOTHER 14. Maiden name Margaret Mickley

15. Birthplace Penna

16. Informant Mrs. Fannie H. Baumgardner

Address New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 - 1948 (month) (day) (year)

Cemetery or crematory Elohra Cemetery

Location near Centerview Penna

18. Funeral director D.D. Hartzler & Sons

Address Union Bridge & New Windsor, Md

19. Oct 26 1948 (Date rec'd by registrar) Emma L. Burdit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948 at 12:01 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Artery disease — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner M. D. or other

Address Westminster, Md Date signed 10/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10307

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Millers Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Millers Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Bollinger

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Annie E Bollinger
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): February 11, 1875
8. AGE: Years: 73 Months: 8 Days: 11 If less than one day: hrs. min.
9. Birthplace: Millers Md (Town, county, and state)
10. Usual occupation: Retired Butcher
11. Industry or business: Retail meats
FATHER 12. Name: Oliver Bollinger
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Wareheime
15. Birthplace: Md
16. Informant: Annie E Bollinger
Address: Millers Md
17. Burial (Burial, cremation, or removal): Burial Date thereof: Oct 25/48 (month) (day) (year)
Cemetery or crematory: Black Rock Brethren
Location: Black Rock, Penna
18. Funeral director: Edw. C Tipton
Address: Hampstead Md
19. Oct. 23 1948 (Date rec'd by registrar) Mrs. H. G. S. Lemmon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1948, at 6:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1948 to Oct 22 1948 and that I last saw h[illegible] alive on Oct 22 1948

Immediate cause of death	DURATION
Acute Myocarditis	1
Due to Generalized Atherosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph E Bush Md
M. D. or other
Address: Hampstead Md Date signed 10-22-48

10308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 2-21-48

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since 2-21-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BRODE, John Cycrons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1867

8. AGE: Years	Months	Days	If less than one day
81	9	2	____ hrs. ____ min.

9. Birthplace: Hoffman, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Stationery Engineer (15 yrs ago)

11. Industry or business: ----

FATHER

12. Name: Patrick Brode

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Kirby

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/6/48 (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Oct. 3 1948 (Date rec'd by registrar) C. Harry Wenn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1948 at 2,20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1948 to October 3 1948 and that I last saw him alive on October 3 1948

Immediate cause of death	DURATION
Arteriosclerosis	18 yrs
Due to	
Due to	

Other conditions: Arterioscl. gangrena of foot 3 mo

Psychosis with cerebr. arterioscler. 18 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Martin Gross, M.D.

Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 10-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10309

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 4 months 8 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored B ranch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: % Lawson King
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Melvin Thomas Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colo	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1920

8. AGE: Years	Months	Days	If less than one day
28	7	29	hrs. min.

9. Birthplace: Rockville, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: James Brown
13. Birthplace: Germantown, Md.

MOTHER
14. Maiden name: Mary Owmly
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-2-48 (month) (day) (year)
Cemetery or crematory: Brownsburg Cem.
Location: Germantown, Md.

18. Funeral director: D C Gaithers
Address: Gaithersburg, Md.

19. October 31 1948 (Date rec'd by registrar) Albert A. Somerville local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1948, at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1947 to October 31 1948 and that I last saw him alive on October 31 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	September 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Fowler, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 10-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

10310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17- (If outside city or town limits, write RURAL and give nearest town)

Street No. 628 N. Carrollton Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES BUTCHER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 20, 1920

8. AGE: Years: 28 Months: Days: 2 If less than one day: hrs. min.

9. Birthplace: Catonsville, Maryland (Town, county, and state)

10. Usual occupation: Huckter

11. Industry or business:

FATHER — 12. Name: Josiah Butcher

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Margaret Hawkins

15. Birthplace: Howard Co. Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Gilboa Cem.

Location: Della Howard Co. Md.

18. Funeral director: Mr. Samuel T. Hemby

Address: 6-78 W. Biddle Street

19. Oct. 22 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 19 48 at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 48 to Oct. 22 19 48 and that I last saw him alive on October 22 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lehman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 10/22/48

10311

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52p

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Finksburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Finksburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Emma Alberta Caltrider

3.(b) Social Security Number: 213-05-1289

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles L. Caltrider

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): April 11, 1880

8. AGE: Years	Months	Days	If less than one day
68	5	21	...hrs. ...min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Francis B. Yingling
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie E Harry
15. Birthplace: Maryland

16. Informant: Charles L. Caltrider
Address: Finksburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10/6/48 (month) (day) (year)

Cemetery or crematory: Providence Cemetery

Location: Gamber, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/4/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3rd 1948, at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10th 1948, to October 3rd 1948 and that I last saw h.. alive on October 3rd 1948

	DURATION
Immediate cause of death	
Due to Carcinoma of Kidney	8 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Preston Boyer (M.D.)
M.D. or other

Address: Westminster, Md. Date signed: 10/5/48

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PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10312

932

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

112 E. Green St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 E. Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Margaret Elizabeth Cash

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife Edward O. Cash

6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1864

8. AGE:

Years	Months	Days	If less than one day
84	8	6	hrs. min.

9. Birthplace Johnsville Fred Co. Md.

(Town, county, and state)

10. Usual occupation Home - wife

11. Industry or business

FATHER

12. Name Richard Buckey

13. Birthplace Fred Co. Md.

MOTHER

14. Maiden name Susan Wolfe

15. Birthplace Fred. Co. Md.

16. Informant Mrs. E. O. Cash

Address 112 E. Green St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22/48 (month) (day) (year)

Cemetery or crematory Haugh's Lutheran Cemetery

Location near Middleburg Fred Co. Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 10/20 19 48 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19th 19 48 at 11.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 - 19 48, to Oct 19, 19 48 and that I last saw h er alive on Oct 19th 19 48

Immediate cause of death	DURATION
acute Cardiac Decompensation.	10 hrs
acute Interstitial Nephritis	5 days
Due to Chronic myocarditis	1 year
Due to Left Hemiplegia	9 mos
Other condition Arteriosclerosis	7 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R Fouts M.D. or other

Address Westminster Md. Date signed 10-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10313

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours, 20 min.

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 23
(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 N. Arlington Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Mae Connor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Separated

6.(b) Name of husband or wife: John Albert Connor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 31, 1921

8. AGE: Years	Months	Days	If less than one day
26	11	25	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Joseph Jeeter
13. Birthplace: Virginia

MOTHER
14. Maiden name: Emme Patterson
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29 1948 (month) (day) (year)

Cemetery or crematory: Mt. Olivet BALTIMORE NATIONAL CEMETERY

Location: Balto. Md.

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Chrender St

19. October 26, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 1948, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26, 1948 to October 26, 1948 and that I last saw her alive on October 26, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	December 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Isaacs, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 10-26-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

10314

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Keymar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keymar

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Benjamin A. C. Craig

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1872

8. AGE:

Years	Months	Days	If less than one day
76	3	18	hrs. min.

9. Birthplace Arn Prior, Canada

(Town, county, and state)

10. Usual occupation Mining Engineer

11. Industry or business

FATHER 12. Name Donald C. Craig

13. Birthplace Buckingham, Quebec, Canada

MOTHER 14. Maiden name Eliza A. D. Coade

15. Birthplace Ottawa Canada

18. Informant Mrs J. A. Dutcher

Address 1120 Virginia Ave. S.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9 1948 (month) (day) (year)

Cemetery or crematory Cedar Falls Cemetery

Location Falls Church, Virginia

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19 Oct. 8 1948 (Date rec'd by registrar) Fanny M. Bumgardner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-48 19 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5-48 19 to 10-7-48 19

and that I last saw him alive on 10-6-48 19

Immediate cause of death	DURATION
Cardiac Failure	
Due to Coronary Artery Disease	6 mos. (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Bradley M.D. M. D. or other

Address Taneytown, Md. Date signed 10-7-48

10315

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County H Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Months, 19 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 434 High Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Rose Belle Cromwell

3. (b) Social Security Number 215-20-4711

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) May 10, 1927

8. AGE: Years	Months	Days	If less than one day
21	4	26	hrs. min.

9. Birthplace Cambridge, Maryland
(Town, county, and state)
10. Usual occupation Factory Worker
11. Industry or business

FATHER
12. Name Elizah Cromwell
13. Birthplace Maryland

MOTHER
14. Maiden name Estelle King
15. Birthplace Maryalnd

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/48 (month) (day) (year)
Cemetery or crematory Cemetery
Location Madersons, Md
19. Funeral director Lewis H Bowman (Company)
Address 201 Washington Blvd Md

19. October 6, 1948 (Date rec'd by registrar) Albert R. Saunders Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1948 to October 6, 1948 and that I last saw her alive on October 6, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Maryland Date signed 10-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10316

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 21 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 W. Hamburg Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BERNICE MAE CROWDER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1941

8. AGE: Years	Months	Days	If less than one day
7	3	13	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:

FATHER
12. Name: Roosevelt Crowder
13. Birthplace: Halifax, Virginia

MOTHER
14. Maiden name: Grace Scott
15. Birthplace: Halifax, Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22 40 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Baltimore, Md.

18. Funeral director: Isaac H. Brown Son
Address: 1521 Montgomery St

19. Oct. 19 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1948, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1948, to October 19 1948, and that I last saw her alive on October 19 1948.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 15, 1948
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 10/19/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Be 94a

10317

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CARROLL

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 29 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 212 East 20th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: (HARRY DAVIS) WILLIAM HARRISON DAVIS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Sadie J. (Smith)

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 18, 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	6	8		

9. Birthplace: Newcastle, Pennsylvania
(Town, county, and state)

10. Usual occupation: Male nurse

11. Industry or business

FATHER
12. Name: William L. Davis
13. Birthplace: unknown

MOTHER
14. Maiden name: Margaret Helen?
15. Birthplace: unknown

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 10/28/48 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 10/27 19 48 C.W. Hellmuth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 19 48 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 19 48, to October 26 19 48 and that I last saw him alive on October 26 19 48

Immediate cause of death	DURATION
Acute myocardial infarction	5 mins.
Due to: Generalized arteriosclerosis	1 yr.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	2 months

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 10/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10318

83a

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years, 9 months, 3 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 15 years, 9 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4203 Groveland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charlotte Debring

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Clarence Debring
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): March 5, 1886

8. AGE: Years	Months	Days	If less than one day
62	7	9	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Charles F. Rappold
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Meinhardt
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18 48 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto. Md.

18. Funeral director: Lanahan Funeral Home
Address: 7401 Belair Rd.

19. Oct. 14 1948 (Date rec'd by registrar) C. Harvey Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1948 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to October 14, 1948 and that I last saw her alive on October 13, 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	4 days
Due to: Arterial hypertension over	16 years
Due to:	
Other conditions: Schizophrenia, catatonic type over	18 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hekmeier M.D. M. D. or other
Address: Springfield State Hospital Date signed: 10-14-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10319

932

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead - (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida May Dell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife: J. Grant Dell

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 4 - 1876

8. AGE:

Years	Months	Days	If less than one day
72	7	8	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John D. Algire

13. Birthplace: Maryland

MOTHER

14. Maiden name: Ella Lepley

15. Birthplace: Maryland

16. Informant: J. Grant Dell

Address: Westminster, Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 15/48 (month) (day) (year)

Cemetery or crematory: Medley

Location: Carroll Co Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Oct. 13 (Date rec'd by registrar) 19 48 John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 19 48 at 7 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 48 to October 12 19 48 and that I last saw h alive on October 10 19 48

Immediate cause of death	DURATION
Central Thrombosis	2 mo.
Due to: Chronic Myocarditis	?
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: — —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other

Address: Hampstead Md Date signed: 10-12-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 10320

Reg. Diat. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Uniontown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Uniontown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Hilda Louise Devilbiss

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1948

8. AGE: Years | Months: 7 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hanover, Pa.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Floyd W. Devilbiss
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna M. Arnold
15. Birthplace: Maryland

16. Informant: Mrs. F. W. Devilbiss
Address: Uniontown, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/10/48 (month) (day) (year)

Cemetery or crematory: St. Paul's Lutheran Cem.

Location: Uniontown, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. Oct 9 1948 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1948, at 11½a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5th 1948 to Oct 7. 1948

and that I last saw h-e alive on Oct 7 1948

	DURATION
Immediate cause of death: Meningitis	8 hrs
Due to: Broncho Pneumonia	48 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. R. Fout M.D. M. D. or other

Address: Westminster Md. Date signed 10-7-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10321

97

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? July 28, 1948
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? July 28, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: --- Frederick (If outside city or town limits, write RURAL and give nearest town)
Street No. --- East Seventh Street (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: DRONEBURG, Harry Clayton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: --- Esta House
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): March 15, 1872

8. AGE: Years	Months	Days	If less than one day
76	--7	3	---m. ---hrs. ---min.

9. Birthplace: Frederick County, Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: ---

FATHER
12. Name: --- Jacob Henry Droneburg
13. Birthplace: --- Jefferson, Md.

MOTHER
14. Maiden name: --- Mary Catherine Creager
15. Birthplace: --- Jefferson, Md.

16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/21/48 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick, Md

18. Funeral director: M.R.Ecchison and Son
Address: Frederick, Md

19. Oct. 20 1948 (Date rec'd by registrar) Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1948 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1948 to October 18 1948 and that I last saw him alive on October 18 1948

Immediate cause of death	DURATION
Arteriosclerosis	unkn.
Due to: ---	
Due to: ---	
Other conditions: Senile psychosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Martin Gross, M. D. Martin Gross, M. D. M. D. or other
Address: Sykesville, Maryland Date signed: 10/18/48

M

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J

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

950 10322

Reg. Diat. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Velma P. Eyler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1915

8. AGE: Years	Months	Days	If less than one day
32	11	15	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name William M. Vaughn

13. Birthplace Md

MOTHER 14. Maiden name Carrie J. Wantz

15. Birthplace Md.

16. Informant Mrs. William M. Vaughn

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1948. (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Oct 4, 1948 Ethel M. Mehring Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral embolus	
Due to Rheumatic heart disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Sharrer Deputy Medical Examiner

M. D. or other

Address Westminster Md Date signed 10/2/48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

122a

10323

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 yrs., 11 mos., 8 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 21 yrs., 11 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2015 Ramsey St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas E. Finneran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	4	14		

9. Birthplace: Baltimore City, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: William H. Finneran
13. Birthplace: Ohio
MOTHER 14. Maiden name: Frances Stewart
15. Birthplace: Baltimore City
16. Informant: Hospital records
Address:
17. Burial, cremation, or removal. Which? Burial Date thereof: October 6-1948 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore Md
18. Funeral director: Duff C & B.M. Walters
Address: Prado Street & Baltimore
19. 10-5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3, 1948 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25, 1926 to Oct. 3, 1948 and that I last saw him alive on Oct. 2, 1948

Immediate cause of death	DURATION
Generalized peritonitis resulting from intestinal obstruction	2 days
Due to:	
Due to: Indirect inguinal hernia	14 yrs.
Other conditions: Psychosis with mental deficiency	22 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 10/3/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10324

83a

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Marriottsville Road

(If rurel, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Jabez Giffin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 10, 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	6	24		

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: Benjamin F. Giffin
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza C. Hale
15. Birthplace: Md.

16. Informant: Wm. H. Giffin
Address: 1813 Whitmore Ave, Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7 1948 (month) (day) (year)
Cemetery or crematory: Springfield Cem.,
Location: Sykesville, Md.

18. Funeral director: Harry Kerr
Address: Sykesville Md.

19. Oct. 6 1948 (Date rec'd by registrar) Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/4 1948, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/4 1948, to 10/4 1948

and that I last saw h[illegible] alive on 10/4 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 hrs
Due to: Hypertension	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. A. Barnes M.D. M. D. or other

Address: Sykesville Md. Date signed 10/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10325

93d

Reg. Dist. No. 72

1. PLACE OF DEATH:

County: Carroll

City or town: Myers District

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ years

Hospital, institution, or street address where death occurred:

Westminster, R. D. 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Littlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah ANN Harner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James J. Harner

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March 6 1865

8. AGE: Years	Months	Days	If less than one day
83	7	12	hrs. min.

9. Birthplace: Adams County, Pa. (Town, county, and state)

10. Usual occupation: Retired Housework

11. Industry or business: Retired Housework

FATHER

12. Name: Joseph Heagy

13. Birthplace: Adams County, Pa.

MOTHER

14. Maiden name: Rebecca Rife

15. Birthplace: Adams County, Pa.

16. Informant: Mervin J. Harner

Address: Littlestown, Pa. R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/21/48 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Cemetery

Location: Littlestown, Pa.

18. Funeral director: E. W. Little & Son

Address: Littlestown, Pa. Per - R.A. Little

19. Oct. 20th 1948 (Date rec'd by registrar) Calvin T. Baumgardner Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH: October 18 1948, at 10:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1947 to Oct. 18 1948 and that I last saw h... alive on October 17 1948

Immediate cause of death — DURATION

Chronic Myocarditis and — 10 yrs.

Myocardial Degeneration

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

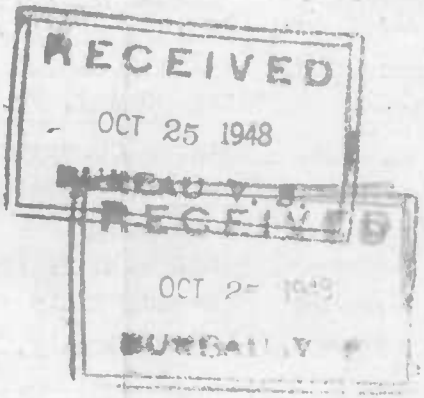
23. SIGNATURE: L. L. Potter M.D. M. D. or other

Address: Littlestown, Pa. Date signed: 10-19-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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10326

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1209 E. Lexington Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SOLOMON HARRIS

3.(b) Social Security Number: 213-09-5188

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 4, 1911

8. AGE: Years	Months	Days	If less than one day
37	5	3	hrs. min.

9. Birthplace: Rocky Mount, N.Carolina
(Town, county, and state)
10. Usual occupation: Packer
11. Industry or business

FATHER
12. Name: Sam Harris
13. Birthplace: Rocky Mount, N.Carolina

MOTHER
14. Maiden name: Susie Whitfield
15. Birthplace: Rocky Mount, N. Carolina

16. Informant: Deceased
Address

17. Removal
(Burial, cremation, or removal. Which?) Date thereof Oct 11 1948
(month) (day) (year)
Cemetery or crematory: Balto city morgue
Location: Mrs. Samuel T. Hemsley
18. Funeral director: 578 W. Biddle St
Address

19. Oct. 7 1948 Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1948 at 3:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1948 to October 7 1948 and that I last saw him alive on October 7 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Roman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 10/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1242

10327

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster-rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

Carroll Co. Alms House

How long in hospital or institution? 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Harrison, Joshua

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Jennie Harrison

6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1874

8. AGE: Years: 74 | Months: 9 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Wesley Harrison

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza A. Baker

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Nettie V. Conaway

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 10-23-48 (month) (day) (year)

Cemetery ~~or crematory~~: Prospect

Location: Nr. Mt. Airy, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 10/23 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21, 1948 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948, to 10-21 1948

and that I last saw h... alive on 10-20-48 19...

Immediate cause of death	DURATION
Pulmonary Edema	5 days
Due to Arteriosclerosis Hypertrophic Cardiosis	25 yrs
Due to Incidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. C. Stone M. D. or other

Address: Westminster Date signed: 10-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

10328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since July 25, 1941

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since July 25, 1941

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 Fayette St.? 817 S. Bond St.?

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: HARTOG, Nicholas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ——

6.(c) If alive, give age: ____ years

7. Birth data of deceased (mo., day, yr.): July 6, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	6	____ hrs. ____ min.

9. Birthplace: Rotterdam, Holland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Martinus Hartog

13. Birthplace: Holland

MOTHER — 14. Maiden name: Jeanette Snatnuse

15. Birthplace: Holland

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-48 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Henry Weer

Address: Sykesville, Md.

19. Oct 14 1948 C. Henry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1948, at 2.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1948, to October 12 1948 and that I last saw him alive on October 11 1948

	DURATION
Immediate cause of death: Chronic myocarditis and myocardial degeneration	25 days
Due to:	
Due to:	
Other conditions: Chronic alcoholism	more than 7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: —— Date of op. ——

Autopsy results: ——

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work?

23. SIGNATURE: Martin Gross, M.D. Martin Gross, M.D. M. D. or other

Address: Sykesville, Md Date signed 10-12-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10329

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 20 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1611 Clifton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DOROTHY CATHERINE HOLTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1924

8. AGE: Years 24 | Months 3 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name George Henry Holton

13. Birthplace St. Mary's County, Maryland

MOTHER 14. Maiden name Martha Lee Holley

15. Birthplace St. Mary's County, Maryland

16. Informant Deceased

Address

17. Burial Date thereof Oct. 7-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Calvary Cem.

Location Brooklyn, Md.

18. Funeral director Elroy O. Wilson

Address 1000 Bruntes Ave

19. Oct. 5 1948 Albert R. Lewis Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1947, to October 5 1948 and that I last saw her alive on October 5, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1947.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W. Foman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 10/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93E

10330

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Maple Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Maple Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Martha E Haltzues

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Lewis Haltzues

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 15 - 1865

8. AGE: Years	Months	Days	If less than one day
83	7	21	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name David Utz
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Bolden
15. Birthplace Maryland

16. Informant Mrs Wesley Mills
Address Maple Grove Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9/48 (month) (day) (year)
Cemetery or crematory Greenmount
Location Carroll Co Md

18. Funeral director Edw. S. Tipton
Address Hampstead Md

19. Oct 7th 1948 (Date rec'd by Registrar) Mrs. W. P. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1947, to Oct. 6 1948
and that I last saw h[illegible] alive on Oct 4 1948

Immediate cause of death	DURATION
Cerebral Haemorrhage	?
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joel E. Bush Md M. D. or other
Address Hampstead Md Date signed 10-7-48

PLEASE WRITE FAMILY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

182

10331

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 11 mo. 27 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 11 mo. 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Eva Frances Hutchins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 14 - 1914

8. AGE: Years: 34 | Months: 6 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER

12. Name: Andrew Hutchins

13. Birthplace: Westernport Md

MOTHER

14. Maiden name: Mary Baldwin

15. Birthplace: Westernport Md

16. Informant: Mrs Mary Esta Hutchins

Address: 223 Walnut St Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-11-48 (month) (day) (year)

Cemetery or crematory: Westernport

Location: Westernport, Md.

18. Funeral director: D. L. Boal

Address: Westernport, Md.

19. Dec. 8 1948 (Date rec'd by registrar) C. Harry Wece Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1948, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation	
Due to: Epilepsy - Grand Mal	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Dec 8, 1948

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): Springfield State Hospital

Means of injury: Epileptic Seizure & fall injured at work? No.

23. SIGNATURE: James T. Morrell, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: Dec 8/1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10332

Bl 13t

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 17 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 620 East 31st Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MILLARD NELSON HUBBARD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M Divorced

6.(b) Name of husband or wife: Ethellyn Piercy Hubbard

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): November 13, 1893

8. AGE: Years	Months	Days	If less than one day
54	11	13	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Manager, A&P Food Stores

11. Industry or business: Grocery store

FATHER
12. Name: Charles Edwin Hubbard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Virginia Hahn
15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10 27 48 (month) (day) (year)

Cemetery or crematory:

Location: 1217 St Paul St Baltimore Md

18. Funeral director: Williams Cook, Inc.

Address: 1217 St Paul St.

19. Oct 28 1948 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 19 48 at 11:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1948 19... to October 26 19 48 and that I last saw h... im alive on October 26 19 48

Immediate cause of death	DURATION
Pulmonary tuberculosis	6 mos.
Due to:	
Due to:	
Other conditions: Psychosis with chronic alcoholism, Korsakoff's syndrome (Include pregnancy within 3 months of death)	7 yrs.

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 10/26/48.

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10333

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 445 N. Jonathan Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JOHN MARCELLIS JONES

3. (b) Social Security Number: 214-09-4175

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Evva Jones

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): September 4, 1913

8. AGE: Years	Months	Days	If less than one day
35	0	27	..... hrs. ..... min.

9. Birthplace: Hagerstown, Maryland
(Town, county, and state)

10. Usual occupation: Restaurant Work

11. Industry or business:

FATHER
12. Name: John Jones
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Marie Robinson
15. Birthplace: Virginia

16. Informant: Wife - Mrs. Evva Jones

Address: 445 N. Jonathan Street, Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 4, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: William H. Downes

Address: 291 Frederick St. Hagerstown Md.

19. Oct. 1 1948 (Date rec'd by registrar) Albert R. Smith Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 19 48 at 5:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20 19 48 to October 1 19 48 and that I last saw him alive on October 1 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rubey W. Fraser, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 10/1/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10334

930

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME J. Earl Lantz

3.(b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband or~~ wife: Mabel Hann Lantz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8 - 1893

8. AGE: Years: 55 Months: 1 Days: 7 If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md

(Town, county, and state)

10. Usual occupation: Produce Dealer

11. Industry or business

FATHER — 12. Name: John M. Lantz

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ella Steiger

15. Birthplace: Maryland

16. Informant: James M. Lantz

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/48 (month) (day) (year)

Cemetery or crematory: Winters Cemetery

Location: Union Bridge Road

18. Funeral director: C. O. Hartle & Sons

Address: Union Bridge & New Windsor, Md.

19. Oct 17 1948 (Date rec'd by registrar) Edna S. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1948 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1948 to Oct 15 1948 and that I last saw him alive on Oct. 15 1948

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Rheumatic Cardio-Vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Merritt E. Robertson M. D. or other

Address: New Windsor, Md. Date signed: Oct 16, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10335

Reg. Dist. No. 774

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Maryland

If veteran, name war:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Waldorf, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

3. (a) FULL NAME: JOHN WILMER MCPHERSON

3. (b) Social Security Number: 213-22-0366

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Evelyn Mc Pherson

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): March 21, 1913

8. AGE: Years	Months	Days	If less than one day
35	6	9	hrs. min.

9. Birthplace: Waldorf, Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: James McPherson

13. Birthplace: Waldorf, Maryland

MOTHER 14. Maiden name: Eleanor Butler

15. Birthplace: Waldorf, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 7 1948 (month) (day) (year)

Cemetery or crematory: St. Paul's cemetery

Location: Waldorf, Maryland

18. Funeral director: Hunter & Myers

Address: Waldorf, Md.

19. Oct. 5 1948 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1948, at 9:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1948 to October 5 1948 and that I last saw him alive on October 5 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 26, 1947.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 10/5/48

Evidence for change of birth date shown on:

10336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

FILM No. G 117 NOV 1 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7 6

1. PLACE OF DEATH:

County Carroll

City or town Finksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Deer Park Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Adam Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 13, ~~1870~~ 1869

8. AGE: Years	Months	Days	If less than one day
78	11	12	..... hrs. ..... min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Jacob Miller

13. Birthplace Carroll Co.

MOTHER 14. Maiden name Elizabeth Arnold

15. Birthplace Carroll Co.

16. Informant Goldie Hensley

Address Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1948 (month) (day) (year)

Cemetery or crematory Finksburg

Location Carroll Co.

18. Funeral director J. Elmer Sms

Address Reisterstown, Md.

19. 10/27/48 (Date rec'd by registrar) I. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-1930 to 10-25-1948 and that I last saw h.y. alive on 10-24-48 19....

Immediate cause of death Broncho-pneumonia — DURATION 2 days

Due to Myocarditis chronic - decompensation — 2 yrs

Due to arteriosclerosis - general

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jesse G. Lobb M. D. or other

Address Reisterstown, Md. Date signed 10-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, making the correct entry in each case. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

10337

Reg. Dist. No. 83

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Benett

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louisa Myers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Thomas Myers (deceased). 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1873

8. AGE:

Years	Months	Days	If less than one day
75	0	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Rod Dorsey

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Jemima

15. Birthplace: Maryland.

16. Informant: Daisy Mae Cook

Address: Sykesville. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-30-48 (month) (day) (year)

Cemetery or crematory: Mt. Zion.

Location: M. Mt. Cem. Carroll Co. Md.

18. Funeral director: C. M. Watts

Address: Winfield, Md.

19. Oct 30 19 48 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27 1948 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 5 1948 to Oct. 25 1948 and that I last saw her alive on Oct 20 1948

Immediate cause of death	DURATION
Arteriosclerotic heart disease	2 yrs
Due to	
Due to	
Other conditions: Edema	3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Reese Wilkens M. D. or other

Address: Westminster Md Date signed: 10/28/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

175c

10338

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct name if is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town) Rural

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wilmer Brumbaugh Myers

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Geraldyn W. Myers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27 - 1905

8. AGE: Years	Months	Days	If less than one day
43	4	12	hrs. min.

9. Birthplace: James Creek, Penna. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Frank Myers

13. Birthplace: Penna.

MOTHER 14. Maiden name: Agnes Brumbaugh

15. Birthplace: Penna

16. Informant: Mrs. Geraldyn W. Myers

Address: New Windsor, Md. R. D.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 10/11/48 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. C. Hartzler & Son

Address: Union Bridge & New Windsor, Md

19. Oct 9 1948 Erma S. Burnett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1948 at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~alive on~~ 19 to 19

and that I last saw h 19

Immediate cause of death: Fracture of Cervical Vertebrae — Fracture Spinal Cord

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10-9-48

Where did injury occur? New Windsor (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): Home - Farm

Means of Injury: Struck by falling tree Injured at work? Yes

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 10/9/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

10339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos 11 days.

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 6 mos 11 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 W 37th St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Agnes Goel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 20th 1865

8. AGE: Years: 83 | Months: 8 | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pa (Town, county and state)

10. Usual occupation: Housework at home

11. Industry or business:

FATHER — 12. Name: Joseph Kuhn

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Sarah Carlin

15. Birthplace: Pa

16. Informant: Marie Anna L. Goel

Address: 401 W 37th St Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28-1948 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Maryland

18. Funeral director: Burgee Funeral Home

Address: 3631 Falls Road

19. Oct. 24 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24 1948, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 13 1948 to Oct 24 1948 and that I last saw h... alive on Oct 23 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to: Uremic Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or Other

Address: Sykesville Md. Date signed: Oct 24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10340

932

Reg. Dist. No. 16

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

Methodist Church Home

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: East Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Alice Lillian Oeligrath

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: [redacted]

(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): January 12, 1859

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
89	9	16		

9. Birthplace: Freeland, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Abraham Oeligrath

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Amelia Marseilles

15. Birthplace: Maryland

16. Informant: Mrs. George Mather

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10/30/48 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Freeland, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/25/48 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 19 48 at 1½a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 48 to Oct 28 19 48

and that I last saw h[illegible] alive on Oct 26 19 48

Immediate cause of death	DURATION
Cardiac Decompensation	
Sclerosis	
Due to: Chronic Myocarditis	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Westminster Date signed: 10/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10341

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 1-18-46

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since 1-18-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1317 North View Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: PFEIL, William H.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertha Nolkr

6.(c) If alive, give age: 42 ? years

7. Birth date of deceased (mo., day, yr.): November 6, 1902

8. AGE: Years	Months	Days	If less than one day
45	11	7	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Shipyard worker

11. Industry or business: ---

FATHER — 12. Name: Frederick Pfeil

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Margaret Burkmeies

15. Birthplace: Maryland

16. Informant: Records of Springfield St. Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-3-48 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Balto. Md.

18. Funeral director: Lilly & Zeiler, Inc.

Address: 403 S. Wolfe St.

19. Oct. 31 1948 C. Harry Ickes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1948, at 7.12 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1 1947, to October 30 1948 and that I last saw him alive on October 30 1948

Immediate cause of death: Carcinoma of tongue — DURATION: 1 yr

Due to:

Due to:

Other conditions: Psychosis with chronic alcoholism, peripheral neuritis. — about 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 10-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

820

10342

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Springfield State Hospital.

How long in hospital or institution? 4 Months 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 704 Lanark Way
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: PHELPS, Charles S.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Catherine Bonds, dec.

6.(c) If slvs, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 1874.

8. AGE: Years	Months	Days	If less than one day
74	6	-	____ hrs. ____ min.

9. Birthplace: Liverpool, England
(Town, county, and state)

10. Usual occupation: Interior decorator & plaster

11. Industry or business: ----

FATHER
12. Name: Unk.
13. Birthplace: England

MOTHER
14. Maiden name: Mary Duval
15. Birthplace: England

16. Informant: Records of Springfield St. Hospt.
Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 9 48 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington, D.C.

18. Funeral director: W. W. Chambers Co.
Address: 1801 Cleveland Ave. Penicdge Md.

19. Oct. 8 1948 (Date rec'd by registrar) C. Harry Mew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1948, 19 at 5:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1948, to October 7, 1948, and that I last saw him alive on October 7, 1948.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 Wk.
Arteriosclerosis	10 Yrs.
Hypertension	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 10/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10343

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 17,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 715 W. Lanvale Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Edward Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Bertina Phillips

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): March 15, 1876

8. AGE: Years	Months	Days	If less than one day
72	7	13	..... hrs. ..... min.

9. Birthplace: Kent County, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Alec Phillips

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Henson

15. Birthplace: Maryland

18. Informant: Deceased

Address: B

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 1 1948 (month) (day) (year)

Cemetery or crematory:

Location: Worton Point Kent county Md.

18. Funeral director: Mrs Katie R. Williams

Address: 322 N. Schroeder St

19. October 28, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1948, at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30, 1948 to October 28, 1948 and that I last saw her alive on October 28, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	January 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Nelson D. Rowan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 10-28-48

10344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1318

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs.
Hospital, Institution, or street address where death occurred:
3-9½ Liberty
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3-9½ Liberty
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minnie Alice Pittinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Charles L. Pittinger
6.(c) If alive, give age 3-6 years

7. Birth date of deceased (mo., day, yr.) June 26 - 1880

8. AGE: Years	Months	Days	If less than one day
68	3	21	..... hrs. ..... min.

9. Birthplace Rocky Ridge Fred. Co. Md.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name John Wm. Eyler
13. Birthplace Springfield, Illinois

MOTHER
14. Maiden name Hannah V. Derr
15. Birthplace Fred. Co. Md.

16. Informant Mrs Minna Otto
Address 3-9½ Liberty St. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1948 (month) (day) (year)
Cemetery or crematory Winter Cemetery
Location New Windsor, Md.
18. Funeral director D. Bankard & Son
Address Westminster, Md.
19. 10/15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1948, to Oct. 17 1948
and that I last saw h.e.r alive on Oct. 16 - 1948

Immediate cause of death	DURATION
Myocarditis (Chr)	
Nephritis (Chr)	
Due to	
Due to	
Other conditions Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other
Address Westminster Md Date signed 10-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10345

107

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since March 26, 1948

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since March 26, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Mt. Frostburg (if outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RALSTON, Charles William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1881

8. AGE: Years	Months	Days	If less than one day
67	6	16	..... hrs. ..... min.

9. Birthplace: Garrett County (Town, county, and state)

10. Usual occupation: Farm hand? Coal miner?

11. Industry or business

FATHER — 12. Name: George F. Ralston

13. Birthplace: Garrett County

MOTHER — 14. Maiden name: Sarah Cunningham

15. Birthplace: Garrett County

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-48 (month) (day) (year)

Cemetery or crematory: Frostburg

Location: Frostburg, Md.

18. Funeral director: J. J. Burst & Son

Address: Frostburg, Md.

19. Oct. 13 1948 C. Harry Akers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1948, at 6.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1948, to October 11 1948 and that I last saw him alive on October 11 1948

	DURATION
Immediate cause of death: Bronchopneumonia	5 days
Due to:	
Due to:	
Other conditions: General and cerebral arteriosclerosis (Include pregnancy within 3 months of death)	several years.

Major findings of operations: ----

Date of op. .....

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of .....

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work?

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed 10-11-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1034670

83a

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Emma C. Reaver

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: John T. Reaver
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 1, 1868

8. AGE:

Years	Months	Days	If less than one day
80	2	25	... hrs. ... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John T. Copenhaver
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Stultz
15. Birthplace: Md

16. Informant: Mrs. Harvey D. Leister
Address: R.D. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1948. (month) (day) (year)
Cemetery or crematory: Lutheran Taneytown
Location: Taneytown, Md.

18. Funeral director: C.O. FUSS & SON
Address: Taneytown, Md.

19 Oct 28. 1948 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26th 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23rd 1948 to October 26th 1948 and that I last saw h[illegible] alive on October 26th 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: B. M. Benner MD
M. D. or other
Address: Taneytown Maryland Date signed: Oct. 28, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct spelling. Information is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10347

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 422½ Myrtle Ave.
(If rural, give LOCATION)
Veteran, name war:

3. (a) FULL NAME: RUFUS ROBINSON

3. (b) Social Security Number: Lost

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife:
6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 15, 1883

8. AGE: Years: 65 Months: 0 Days: 28 If less than one day: hrs. min.

9. Birthplace: Disputanta, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Rufus Robinson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Fannie Taylor
15. Birthplace: Prince George's County, Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: OCT 16 1948 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Jones Bros & Co.

18. Funeral director: A. Halstead
Address: 918 Druid Hill Ave

19. Oct. 13 19 48 (Date rec'd by registrar) Albert A. Bruce Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 19 48 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 19 48 to October 13 19 48 and that I last saw him alive on October 13 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 10/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10348

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: He nryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year 26 Days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 N. Schroeder Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LEONARD FRANCES SAVAGE

3. (b) Social Security Number: 227-20-3096

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Separated

6.(b) Name of husband or wife: Georgia Savage

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): December 15, 1896

8. AGE: Years	Months	Days	If less than one day
51	10	3	..... hrs. ..... min.

9. Birthplace: Accomac County, Virginia (Town, county, and state)

10. Usual occupation: Ship Yard Worker

11. Industry or business:

FATHER — 12. Name: Lorenzo Savage

13. Birthplace: Accomac County, Virginia

MOTHER — 14. Maiden name: Caroline Wine[illegible]

15. Birthplace: Accomac County, Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Accomac Co. Virginia

18. Funeral director: J. E. Thomas

Address: Accomac Co. Va.

19. Oct 18 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 19 48 at 10:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22, 19 47 to October 18 19 48 and that I last saw h[illegible]im alive on October 18 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1947.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Roman M.D. M. D. or other

Address: Henryton, Maryland Date signed: 10/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10349

107

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since July 27, 1932 or longer

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since July 27, 1932

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: ?

(If outside city or town limits, write RURAL and give nearest town)

Street No. ———

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SELBY, David U.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 26, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	6	27		

9. Birthplace: Frederick Co. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Eugene F. Selby

13. Birthplace: Carroll Co.

MOTHER — 14. Maiden name: Ida M. Blacksten

15. Birthplace: Carroll Co.

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26, 1948 (month) (day) (year)

Cemetery or crematory: Pipe Creek

Location: Carroll Co. Md.

18. Funeral director: Keen Funeral Home

Address: Sykesville, Md.

19. Oct. 24 1948 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1948 at 9.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to October 23 1948 and that I last saw him alive on October 23 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Psychosis with mental deficiency (Include pregnancy within 3 months of death)	16 yrs

Major findings of operations: ———— Date of op. ———

Autopsy results: Bronchopneumonia, both lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ———— Date of ————

Where did injury occur? ———— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ————

Means of injury ——— Injured at work? ———

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md Date signed: 10-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

10350

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since March 13, 1948

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? since March 13, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---
(If rural, give LOCATION)

2.(a) If veteran, name war ---

3.(a) FULL NAME SMITH, Michael Joseph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Josephine Watson Smith

6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) October 1, 1872

8. AGE: Years	Months	Days	If less than one day
76	0	8	...hrs. ...min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Gardener

11. Industry or business ---

FATHER 12. Name ---

13. Birthplace Ireland

MOTHER 14. Maiden name ---

15. Birthplace Ireland

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11. 48 (month) (day) (year)

Cemetery or crematory St. Charles

Location Pikesville, Md.

18. Funeral director Frank A. Maxwell

Address Pikesville, Md.

19. Oct. 9 1948 C. Harry Weber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1948 at 5.35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1948 1948 to October 9 1948 and that I last saw him alive on October 8 1948

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions Arteriosclerosis Senility (Include pregnancy within 3 months of death)	about 3yrs

Major findings of operations ---

Date of op.

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Martin Gross, M.D.

23. SIGNATURE Martin Gross, M.D.

Address Sykesville, Md M. D. or other

Date signed 10-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

10351

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Route #, Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Estelle May Tomlinson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: John Robert Tomlinson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1901

8. AGE:

Years	Months	Days	If less than one day
46	9	24	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Telephone operator

11. Industry or business:

FATHER

12. Name: Edward Markwood

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Mary Ann Fischer

15. Birthplace: Pennsylvania

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1948 (month) (day) (year)

Cemetery or crematory: Hyattsville

Location: Hyattsville, Md.

18. Funeral director: F. Gaschis Sons

Address: Hyattsville, Md.

19. Oct. 20 1948 (Date rec'd by registrar) A. Fanny Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19, 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1948 to Oct. 19, 1948 and that I last saw h[illegible] alive on Oct. 19, 1948

	DURATION
Immediate cause of death: Bronchopneumonia	1 day
Due to: Acute nephritis	1 wk.
Due to:	
Other conditions: Alzheimer's Disease	2

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph K. Marshall, M.D. M.D. or other

Address: Springfield State Hospital Date signed 10/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10352

941a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
2 Main Westminster (Hoffman Inn)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clarence Eugene Tutman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Jeanne Power
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Federal employee Ret.

11. Industry or business Revenue Dept.

FATHER 12. Name Samuel A Tutman
13. Birthplace Md.

MOTHER 14. Maiden name Nannie Tutman
15. Birthplace Md.

16. Informant Vincent Tutman
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1948 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery, Westminster
Location Westminster, Md.

18. Funeral director H Bankard Son
Address Westminster Md.

19. 10 IE 48 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948 at 8 a.m. Prom t

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary Artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F Marsh Deputy Medical Examiner
M. D. or other
Address Westminster Md. Date signed 10-28-48

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1948
75
1873

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10353

48 ay

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs

Hospital, Institution, or street address where death occurred:

39 Johns St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Johns St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daisy May Turfle

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	married

6.(b) Name of husband or wife Arthur L. Turfle

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 10 - 1894

8. AGE:

Years	Months	Days	If less than one day
54	4	17	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name George W. Mumford

13. Birthplace Frederick Co. Md.

MOTHER

14. Maiden name Annie R. Eyler

15. Birthplace Frederick Co. Md.

16. Informant Arthur L. Turfle

Address 39 Johns St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1948 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard Son

Address Westminster, Md.

19. 10/28/48 19.. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th 1948 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about May 10th 1947, to Oct. 27th 1948

and that I last saw him alive on Oct 27 1948

Immediate cause of death Carcinoma of Cervix — DURATION Probably 2 yrs.

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations Above - from diagnosis at removing Body Date of op. about 6-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Billingsley, M.D. M. D. or other

Address Westminster, Md. Date signed 10-28-48


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10354

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Jan. 25, 1936

Hospital, institution, or street address (where death occurred): Springfield State Hosp.

How long in hospital or institution? since Jan 25, 1936

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2011 E. Lombard Str.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Charles Veltre

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25 1915

8. AGE: Years: 33 | Months: 8 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: odd jobs

11. Industry or business:

FATHER
12. Name: Charles A. Veltre
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Grace Hartel
15. Birthplace: Baltimore Md.

16. Informant: Alexander Veltre
Address: 416 N. Patterson Park Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3 1948 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore Md.

18. Funeral director: Lilley & Geiler Inc.

Address: 403 S. Holfe St.

19. Nov 1 1948 (Date rec'd by registrar) Stanley Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946, to Oct. 31 1948 and that I last saw h.i.m. alive on Oct. 30th 1948

Immediate cause of death	DURATION
Lung Tb	5 years
Due to:	
Due to:	
Other conditions: Schizophrenic catatonic type	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Pulmonary Tb

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos Kernan M. D. or other

Address: Springfield State Hosp. Date signed Oct. 31, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Encircle the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10355

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore 23,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 N. Gilmor Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CORINNE WALLACE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Simgle

6.(b) Name of husband or wife:
6.(c) If alive, give age: yeere

7. Birth date of deceeeed (mo., day, yr.): July 18, 1919

8. AGE:

Years	Months	Days	If less then one day
29	3	5	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usuel occupation: Domestic

11. Industry or business

FATHER
12. Neme: William Wyatt Wallace
13. Birthplece: North Carolina

MOTHER
14. Maiden neme: Nancy Neal
15. Birthplace: North Carolina

16. Informent: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27 '48 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore, Md.

18. Funeral director: Mrs Gafie R. Williams
Address: 322 N. Schroeder St

19. October 23, 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1948, at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18, 1948 to Oct. 23, 1948 and that I last saw her alive on October 23, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	December 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 10-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1780 10356

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Finksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution or street address where death occurred:

Route 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mike Wallen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married (?)

6.(b) Name of husband or wife: Not Known

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
73	—		..... hrs. ..... min.

9. Birthplace: Not Known (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Not Known

13. Birthplace:

MOTHER — 14. Maiden name: Not Known

15. Birthplace:

16. Informant: John Biegl

Address: 2322 Belair Rd - Baltimore Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct. 9, 1948 (month) (day) (year)

Cemetery or crematory: Finksburg

Location: Finksburg Carroll Co.

18. Funeral director: J. F. Eline Sons

Address: Reisterstown, Md.

19. 10/7/48 19..... Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION Over to

20. DATE OF DEATH: October 6, 1948 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death:	DURATION
Asphyxiation	
Due to: Illuminating gas -	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/6/48

Where did injury occur? Finksburg (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Illuminating gas Injured at work? Yes

23. SIGNATURE: James T. Thomas Deputy Medical Examiner

M. D. or other

Address: Westminster Md. Date signed: 10/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10357

932

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 20 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

CARRIE WALTERS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George Walters (deceased)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 8/1/1862

8. AGE: Years	Months	Days	If less than one day
86	1	3	..... hrs. ..... min.

9. Birthplace: Allegany County (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles Kaefer

13. Birthplace: Germany

MOTHER — 14. Maiden name: Dora ?

15. Birthplace: Germany

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 27 1948 (month) (day) (year)

Cemetery or crematory: Fonaconing

Location: Allegany Co. Md.

18. Funeral director: Keen Funeral Home

Address: Sykesville Md.

19. Oct 25 1948 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 48 at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 19 48 to October 24 19 48 and that I last saw her alive on October 24 19 48

Immediate cause of death	DURATION
Myocardial degeneration	2 mos.
Due to: Arteriosclerosis	5 yrs.
Due to:	
Other conditions: Senile Psychosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 10/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age if unknown. Medical certification is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pr 94a

10358

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 mos. 11 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr. 5 mos. 11 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3136 Pentwood Rd. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Carolyn J. Hagan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: James Eugene Hagan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 18th - 1868

8. AGE: Years: 70 | Months: 6 | Days: 15 | If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Lorraine Ohio

10. Usual occupation: School Teacher

11. Industry or business:

FATHER — 12. Name: Dale Richmond

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Frances Richmond

15. Birthplace: Ohio

16. Informant: Mrs. Jaynes W. Nichols

Address: 3136 Pentwood Rd. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1948 (month) (day) (year)

Cemetery or crematory: Euclid Cemetery

Location: Cleveland, Ohio

18. Funeral director: John C. Mitchell & Sons

Address: 1960 Eutaw Place, Balto. Md.

19. Oct 3 1948 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1948, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1947 to Oct 2 1948 and that I last saw her alive on Oct 2d 1948

	DURATION
Immediate cause of death: Coronary Thrombus	1 hr
Due to:	
Due to: Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. G. Gaston M.D. M. D. of other

Address: Sykesville Md. Date signed 10/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10359

130

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Josephine Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1932

8. AGE: Years	Months	Days	If less than one day
16	9	2	hrs. min.

9. Birthplace: Avondale, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Arthur Williams
13. Birthplace: William Fort, Maryland

MOTHER
14. Maiden name: Elsie Mae Squirrell
15. Birthplace: Western Chapel, Maryland

18. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which? Burial Date thereof 11/1/48
(Month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Westminster, Md. R.D.

18. Funeral director: H. W. Hafer Son & Sons

Address: Union Bridge & New Windsor, Md.

19. October 30, 1948
(Date rec'd by registrar)

Albert R. Smith
Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1948, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 1948 to October 30, 1948 and that I last saw her alive on October 30, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	February 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Wolfman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 10-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10360

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 2 mons., 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Huntsville (Landover P.O.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box #69
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES WASHINGTON YATES, JR.

3.(b) Social Security Number: 579-16-4006

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (Sep.)

6.(b) Name of husband or wife: Mattielene Yates
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): April 8, 1920

8. AGE: Years	Months	Days	If less than one day
28	6	16	...hrs. ...min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Power Plant
11. Industry or business:
FATHER 12. Name: James Washington Yates, Sr.
13. Birthplace: Unknown
MOTHER 14. Maiden name: Carrie Queen
15. Birthplace: Maryland
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1948 (month) (day) (year)
Cemetery or crematory: Woodlawn Baptist Cem.
Location: Washington, D.C.
18. Funeral director: John T. Stewart
Address: 30 N. N.W. Wash., D.C.
19. October 24, 1948 (Date rec'd by registrar) Albert R. Swanston Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1948 at 5:A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 28, 1947 to Oct. 24, 1948 and that I last saw him alive on October 24, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Reuben D. Foreman, M.D.
M. D. or other
Address: Henryton, Maryland
Date signed: 10-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10361

Reg. Diat. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Keysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md., County: Carroll
City or town: Keysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Dessie V. Young

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Charles W. Young
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 30, 1876

8. AGE: Years	Months	Days	If less than one day
72	2	26	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: John J. Shryock
13. Birthplace: Md

MOTHER
14. Maiden name: Catherine Anders
15. Birthplace: Md

16. Informant: John W. Young
Address: Keymar, Md.

17. Burial [illegible] Date thereof Oct. 28, 1948 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory: Keysville
Location: Keysville, Md.

18. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.

19. Oct. 27 1948 Jenny M. Powell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1948, at 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1948, to Oct 26 1948, and that I last saw her alive on Oct 26 1948.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed 10-26-48